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ABSTRACT

A series of followup investigations exploring the impact of methadone maintenance treatment, methadone detoxification treatment, therapeutic communities, and outpatient drug-free treatment for the drug abuser was conducted. Limitations of these modalities were revealed in the followup studies. Implications for treatment and policy include: (1) methadone detoxofication as a short-term program is a relatively ineffective treatment technique, but the longer a client remains in treatment, the more likely it is there will be a positive outcome; (2) procedures of intake should make the alternatives available to clients clear to them at time of entry; and (3) aggressive client followup which makes continuing care available to the client at time of exit from the program helps to ensure the client's successful integration into the community. (Author)

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CLINICAL APPLICATIONS OF EVALUATION STUDIES

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I would like to explore with you first some of the implications for clinical practice and policy that might be drawn from the studies just reported and then to explore some of the issues involved in making research results in drug abuse useful to the clinical and planning communities. With regard to results reported from the DARP studies, attention will be paid to three findings that appear to this observer to be of particular significance. The areas selected for exploration are the relative ineffectiveness of detoxification as a treatment modality, the relationship between length of time in treatment and treatment outcome, and the relatively low levels of employment seen at time of follow-up interview.

To deal first with the questionable utility of detoxification as a treatment modality. It will be recalled that detoxification clients were found to fare considerably more poorly than maintenance or therapeutic community clients particularly, and to somewhat lesser extent did more poorly than outpatient drug free clients as well.

Inasmuch as length of time in treatment is significantly related to treatment outcome, it seems hardly surprising that a treatment regimen demanding minimal client involvement is less effective than other, more demanding, modalities. Indeed, one can argue that the clients who enter detoxification differ in motivation for treatment from those who enter the more demanding treatment regimens of maintenance or residential care and that this, in part explains their poorer

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treatment performance. Prior study suggests that clients eligible for maintenance who select detoxification do indeed differ from those selecting maintenance in ways that indicate a larger responsibility felt for themselves and/or their families (Bass and Brown, 1973).

Nonetheless, the DARP findings regarding detoxification invite an effort, if they do not suggest a need, to explore initiatives that might deal with the failure of detoxification as a treatment modality.

The importance of exploring treatment initiatives for use with detoxification clients is further emphasized by an examination of data derived from the ongoing collection of information about clients entering federally funded programs. Of opiate users entering treatment in the most recent period for which data is available, the three month period of October-December 1977, 33 percent opted for detoxification-25 percent of all incoming clients selecting outpatient detoxification, making outpatient detoxification the largest single treatment category among opiate users admitted to treatment. Of larger significance, approximately two-thirds of all admissions to detoxification met the criteria for admission to methadone maintenance and, of course, all met the criteria for admission to therapeutic communities. Finally, during the period of October-December 1977, only four percent of clients admitted to outpatient detoxification were transferred to other treatment programs, i.e. for the vast bulk of detoxification clients recruitment into detoxification was not a part of the treatment experience, it was the treatment experience.

With regard to initiatives for treatment, one obvious option, and perhaps the option most easily exercised, is to make treatment as attractive as possible and return to treatment as free of harassment as possible so that the former client, if experiencing difficulty, can return easily whether to detoxification or to a more demanding regimen. It will be recalled that the DARP data suggests that drug abuse clients generally return to same treatment as that from which they exited with some increase in admissions to maintenance programs.

An additional option, open to many programs, is to regard the intake process as an opportunity to counsel with the client regarding his/her treatment needs and expectations regarding treatment. In that context, discussion can and should focus on the treatment form that best meets client's needs and expectations. This is not meant to suggest that entry into specific modalities be coerced or indeed that the first treatment contact be one of harassment-even if harassment with the best of intentions. It is to suggest that the intake counselor ally himself or herself with the client in meeting the client's needs and indicate those treatment options that exist within the program and/or the community. Only by so doing can the client be given the ability to make an informed choice in terms of his/her situation and concerns. Similar effort can, and should, be made to allow the client to understand the availability, if not desirability, of drug free treatment once detoxification is completed.

A third program option is that of providing to the client followup or continuing care that extends beyond that of the formal treatment

program. Again, cautior must be taken that any such activity does not represent an imposition that the client neither expects nor wants. To some extent this can be handled by clarifying that the treatment experience shall be structured to include client followup. Further, that that followup shall involve on the one hand the provision of services needed as the client returns fully to the community; and on the other, a period of continuing contact with the client to assess progress in the community and to aid in the resolution of problems as appropriate. The services that could be embraced within a continuing care structure are many and would depend on client needs as client and counselor come to view them. Services to be provided could include school or vocational assistance, housing assistance, acquisition of welfare or other benefits, medical or dental care, legal help, etc. While such efforts are encountered in mental health programming, they are far less frequently provided in drug abuse.

Assistance would also be directed toward providing the client with the social supports needed to aid the client in undertaking a new or changed manner of coping with his/her community. The nature of those supports may vary as well. Work can be undertaken in terms of exploring family relationships in an effort to understand whether and to what extent the family can act as a source of support and assistance for the client. As appropriate, effort can be made to shore up those supports. Indeed, it would be important to work with the client in structuring not only his or her work related activities in the community, as described above, but to explore as well the client's leisure time activities including recreational activities and friendship patterns.

It appears obvious that both may be related to the successful adoption of a new, and differing, life style. Moreover, it seems likely that both must be observed and worked with in the client's community since clearly that is the crucible in which a new role and functioning will be forged.

The finding from study of the DARP samples that length of time in treatment is associated with positive outcome would appear to argue for continuing care efforts on behalf of more clients than just those admitted into detoxification regimens. The effort to usefully extend client contact with the service provider may then add further to the impact of treatment already provided. While clearly some number of clients will want no further contact with drug abuse treatment in any form, it seems likely that some number of clients will want and appreciate this community-oriented continuity of effort. Moreover, that effort need not be tied to the workings of a formal treatment program. As an example, increasing interest is being shown in the role that can be played by self-help groups. These groups can provide both the support of peers to the former client's efforts to remain drug free in the community, and can provide as well a stimulus to greater responsibility-taking and a wider range of self-actualizing behaviors.

One is drawn inevitably to compare the drug abuse and alcoholism fields in their use of self-help organizations. While AA is a richly flourishing organization, its counterpart in drug abuse, Narcotics Anonymous or NA, although of undeniable importance, remains a much less vigorous force. Reasons for the far slower growth of non-residential self-

help efforts in drug abuse are numerous and have been explored elsewhere (Brown and Ashery, 1978); however, the utility of such groups in extending the treatment experience while giving needed support to the former client makes them an attractive force for further encouragement and eventual assessment.

Before I digress my way into another symposium, let me return more narrowly to a discussion of the detoxification client. A fourth avenue available for exploration is that of modifying the regulations governing detoxification scheduling and procedure. As effective argument is marshalled, there is opportunity to modify the existing regulations regarding methadone detoxification that limit such activity to a 21 day period. At this point the potential for effecting such change is unclear, however there appear two useful arguments in support of that effort. Both are born of evaluative studies which have been conducted. On the one hand, there is the study of the DARP samples already reported, specifically the relative ineffectiveness of methadone detoxification and relatedly the relationship between positive outcome and length of time in treatment. On the other, there is the work reported by Senay and his colleagues (Senay et al., 1977) that explored among other issues the impact of gradual as opposed to rapid detoxification. It might be noted that rapid detoxification covered a period of 10 weeks whereas gradual detoxification covered a period of 30. The study, conducted under double blind conditions, found significant differences between groups in terms of dropout rates, requests for interruption in withdrawal schedule, rates of urines positive for illicit drugs, and client reports of symptoms. All such differences

favored the gradual detoxification sample. The original study samples involved clients detoxifying from methadone maintenance regimens and a larger effort is currently under way using methadone detoxification clients only, which if supportive of earlier findings, can be presented together with the DARP findings to suggest alternative regulations regarding detoxification scheduling.

Let me turn finally to a brief discussion of DARP findings with regard to employment. While significant differences have been obtained in terms of client employment pre and post-treatment for selected modalities, the percentage reporting themselves as employed at time of followup would appear cause for concern. Only 49 percent of all clients report themselves as employed (where employment may be only one day in the preceding two month period) with a high of 55 percent in therapeutic communities. Indeed, only 35 percent overall reported themselves as employed over half of the two month preceding interview. Yet, employment-or at least productive activity-would seem essential to the client's adopting and maintaining a changed life style. Indeed, investigation of client and staff treatment goals have placed obtaining employment at the top of both groups' lists (Goldenberg, 1972; Mandel et al., 1973). Obviously, new initiatives in the vocational rehabilitation of drug abusers are required.

One such effort that has been recently initiated and appears promising is the supported work program. That program, first developed in association with drug abuse programs in New York City and later expanded to 14 additional cities, provides structured small group work experiences that permit of graduated responsibility-taking in association with

a similarly graduated system of rewards. Preliminary findings from those demonstrations suggest that this technique offers clients greater potential for remaining out of jail, for retaining jobs and making advancement within those jobs than a control sample lacking supported work experience (Friedman, 1978).

If supported work efforts, or variations of those, represent initiatives in vocational rehabilitation available to program and community agency, additional efforts by various governmental agencies will be necessary to modify business and union attitudes. Those attitudes often remain as significant impediments to the obtaining of other than dead-end jobs by drug abuse clients. A still more troublesome impediment remains the state of the economy with its obvious impact on the hiring of individuals of often limited work skills and job histories.

In many respects the ease with which treatment implications are coaxed from work with the DARP samples points up not only the importance and utility of these studies, but raises again the dilemna of bringing researcher/ evaluator and clinician into closer communication with each other. Both have a considerable stake in effecting a better communication process. The researcher, who has elected to engage him- or herself in evaluation study, has moved some distance from more normative, and more traditionally acceptable, academic study and has understandable need to see his or her work translated into action. Indeed it can be argued that the researcher who applies his or her skills in the interest of evaluative research must be, or should be, particularly secure in his or her research credentials. Not only are the dollars available for evaluative study likely to be less than those available

for more largely basic research, but even a hasty perusal of the "good" journals indicates that abstraction is rewarded in a way that application is not. Thus, it has been reported that the researcher who begins to express concern about application runs the risk of losing status among his or her peers (Davis and Salasin, 1977). In that context, then, many researchers, who have invested themselves in policy oriented study, have expressed frustration over their inability to see findings they consider important applied within treatment settings.

The price of missed, or no, communication can be similarly high for the clinician administrator or planner. There is not only a desire on the part of most to remain contemporary with their field and to be acting in accord with the current state of knowledge, but far more importantly there is a desire and a need felt to serve clients in accord with the best information available at the time.

The impediments to improved communication have been well reported particularly in articles by Davis and Salasin, 1977; Mann and Likert, 1952; Weiss, 1973; Kiresuk et al., 1977; Glaser, 1973; Rossi and Williams, 1972; and others. It is worth recounting briefly the forces that have been described as necessary to the development of an effective communication system before discussing communication models that have application to the field of drug abuse. It should be clear that the issue of concern at this point is not the utilization of evaluation study conducted at a single program site by that individual program (although this may be difficult enough), but the utilization of evaluation and research findings by programs other than those in which the studies have been conducted.

As a first consideration, program staff must be open to change. Thus, program staff must see their program as capable of modification and improvement, and must themselves be willing to take guidance from the experiences of others. On the one hand, there must be a concern with enhancing program such that it can better serve clients, on the other there must be minimal defensiveness about oneself and about program such that inadequacies or gaps can be admitted and corrected. If we hazard that a concern for clients will virtually always be the case, we are left to deal with the resistances to program change that can be operative as a function of defensiveness. These have been characterized by Davis and Salasin (1977) as fears of economic loss, fears about personal security, fears about decreased personal convenience, fears about decreased job satisfaction, fears of inability to learn easily new skills and a new role, felt overcommitment, etc. Obviously, depending on the depth of such feelings, more or less work will need to be done to assure program staff of the relative safety of making such changes-assuming, in fact, changes can be safely made.

It should be clear that just as there may be resistances to clear away in the process of implementing change, so too there can be the prospect of rewards to program staff even apart from improved ability to serve clients. Thus, the prospect of developing new skills can bring with it not only a concern about one's adequacy, but also challenge and fresh excitement to a job that may have become routine-to say nothing of containing as well the prospect of greater economic rewards and security.

We come next to the evaluation/research findings themselves. On the one hand, those findings must appear credible. Regarding this latter point, as frustrating as it may be for research staff, t tests or even factor analyses may be insufficient to assure belief if the findings conflict with the clinical experiences of program staff. It may be easy for program staff to assert that the findings apply to other programs and/or to other times, but not to them. Indeed, they may, of course, be correct.

In related fashion, the treatment implications to be drawn from the research conducted must be clear, the relevance of findings to the functioning of that specific program must be apparent, and the actions that will be demanded of program personnel to implement such change must also be clear. What is being structured then is a need to make the implications of findings as program specific as possible and to reduce program resistance to change to the degree feasible. It appears likely that the more nearly communication with program is conducted on a face to face basis the more easily all issues of research utility can be resolved. Indeed, one can posit a continuum extending from face to face discussion between evaluator and program staff to journal article describing research findings, i.e. from an effort at making research findings as concrete and program-specific as possible to an effort to place findings on a plane that is both abstract and general. If the former is rarely achieved, the latter is obtained too frequently. I might indicate paranthetically that a middle ground, that of making research findings available in a language and form that (hopefully) will admit of their greater utility, is a step that staff of TCU have taken in conjunction with staff at the National

Institute on Drug Abuse, as will be described shortly.

Finally, we come to the mundane, if nonetheless crucial, issues of dollars available to the treatment program, personnel needed, space identified, training to be initiated, etc. in support of the application of research/evaluation findings. While there is much to be said for individual initiative and the vertical motion of bootstraps, there is also a good deal to be said for money and adequate resources. Also cited as relevant is the timing of events such that the program initiative can be aligned with other events at the programs, i.e. the initiative occurs at a time when it does not conflict with other significant program activities or organizational circumstances.

The dilemma then remains of making research findings available to service deliverers in a form that can be useful to them in planning new program initiatives. The range and number of program concerns to be considered make clear that no easy solutions will be forthcoming.

The effort to make research findings useful to a clinical audience is one that has been seen as an especial concern of the National Institute on Drug Abuse and has increasingly occupied the Institute's attention. It should be noted that this issue has for considerably longer occupied the attention of NIMH -- and most particularly, the attention of Howard Davis and his staff.

At NIDA, there has been a view that it is the responsibility of the Institute to develop mechanisms for sharing within the field at a minimum that knowledge gained through governmental support. Moreover,

it seems clear at this point that a third actor, as for example the Institute, is useful -if not necessary - to make research findings available to the clinical public. In the main, existing mechanisms to permit communication between researcher and clinician are few and largely inadequate. Journals and, to lesser extent, conferences are primarily the province of the researcher and have not proven terribly useful as a medium of exchange between researcher and clinician.

Two initiatives available to a governmental, or other, agency might then be considered. One makes use of the role of information clearinghouse and deals with written communication only. The second would involve still another actor closer to treatment program and is intended to permit face to face as well as written communication. In the first instance, the adoption of the clearinghouse model, the Institute has undertaken to set some number of research/evaluation findings and reports in a form designed to make them as useful to clinical concerns as possible. Those efforts have involved the publication of materials both in as concise a form as possible and the publication of materials in comparatively non-technical formats. In some instances, there has been the publication of materials in both non-technical and technical forms -- the latter specifically geared to the research audience and to that portion of the clinical audience who seek a fuller statement of methodology and analysis.

A second effort, again within the role of clearinghouse, also involves the publication of materials directed most largely, although not exclusively, to a clinical audience. In this instance, a variety of persons , active in the drug abuse field, have been asked to review

differing issues significant to the role and functioning of the treatment community, e.g., vocational rehabilitation, aftercare, methadone detoxification, etc. Each reviewer has been asked to emphasize research findings of the preceding five years and to develop implications for treatment, for training, etc., as well as for research, all within the space of 10 pages.

In its capacity as clearinghouse, the Institute makes these publications as widely available as money permits -- including mailings to all drug treatment programs known to the Institute. It is apparent that these efforts are intended to approximate more closely than journal articles can a talking to program personnel regarding treatment initiatives that appear useful. As approximations only, they cannot speak directly to specific program needs, resistances, etc. They can alert programs to options they might not previously have considered. In an effort to understand the impact of these tailored publications, <u>if any</u>, study is now being conducted of the use made of them by drug abuse programs.

Clearly, in terms of the ideal of direct face to face contact with program with opportunity to discuss specific program needs and concerns, the clearinghouse role remains very much a half measure. Nonetheless, for some functions, it would appear relatively adequate, e.g., in pointing up the limited utility of detoxification and in encouraging a limited range of program options. In other instances, as for example encouraging novel vocational rehabilitation initiatives, the clearinghouse model may be far less effective.

While the sheer number of treatment programs prohibits any direct interaction for all but a severely limited number of issues, it is possible to structure interactions between consultants - who may help to guide program change - and a smaller number of actors who can relate to a limited number of drug abuse programs. More specifically, in the field of drug abuse, each state is required to have a drug abuse coordinator whose job it is to guide and, in substantial degree, to supervise the workings of drug abuse programs in his or (in two instances) in her state. As such, they have opportunity to be in frequent contact with individual programs and to be knowledgeable about the workings of those programs. These persons, then, would seem to have obvious potential to play the role of change agent in their states, working through the various issues discussed earlier on a program by program basis. (Obviously, too, all of those issues raised for program - resistances to change, understanding of treatment implications of research, adequate resources, etc., would need to be explored with state coordinators as those issues would relate to their individual situations.) Through a use of regional workshops, state agency coordinators and consultant advisors could be brought together to explore treatment initiatives potential in selected areas.

As should be clear, in some instances the evaluator can point the way to a need for new initiatives or to a deficiency in the treatment process, but will not be the appropriate person to guide a programmatic response to that deficiency. Again, difficulties uncovered in the employment of current or former drug abusers would seem to call for new initiatives that might be guided, in part, by persons who have mounted

successful programs in that area. In other instances, where the evaluation task is more narrow, e.g., where specific family counseling approaches have been found effective, the evaluation researcher and clinical staff might play the role of consultant.

By working directly with small groups of those persons who are on the scene in the various states and are charged with significant responsibility for service delivery, effort can be made to relate evaluation findings and implications to specific treatment needs and concerns. Those state coordinators would then be asked to relate, in turn, to individual programs. The counsulting staff could remain available to state coordinators for limited further assistance.

It will be important to experiment with these and other initiatives in an effort to resolve a problem that is not simply one of difficulty in communication between two professional groups, but is one that threatens to limit the effectiveness with which services are provided to client populations.

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